

Samford University
IN-NETWORK BENEFIT COMPARISON – DIFFERENCES ONLY
Blue Cross and Blue Shield of Alabama
Current Plan and Benefit Plan (Effective June 1, 2009)

	Current Plan BlueCard PPO	Benefit Plan (Effective June 1, 2009) BlueCard PPO
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS		
Preadmission Certification is required for inpatient admissions (except maternity); notification within 48 hours for emergencies. Call 1-800-248-2342 (toll free) for precertification.		
Inpatient Hospital Note: In Alabama, inpatient benefits for out-of-network hospitals available only for accidental injury	100% after \$200 per admission deductible; \$50 per day hospital copay days 2-6 for each admission	100% after \$150 per day hospital copay for days 1-5 for each admission, no deductible per admission
OUTPATIENT HOSPITAL BENEFITS		
Outpatient Surgery (including Ambulatory Surgical Centers)	100% after \$100 hospital copay	100% after \$150 hospital copay
Emergency Room (Medical Emergency)	100% after \$100 hospital copay	100% after \$150 hospital copay
Emergency Room (Accident)	100% after \$100 hospital copay	100% after \$150 hospital copay
Emergency Room Physician	100% after \$25 physician copay with no deductible	100% after \$40 physician copay with no deductible
PHYSICIAN BENEFITS		
Office Visits & Consultations	100% after \$25 physician copay with no deductible	100% after \$25 primary care physician copay; \$40 specialist physician copay with no deductible
Second Surgical Opinions	100%; no copay or deductible	100% after \$40 physician copay with no deductible
SUMMARY OF COST SHARING PROVISIONS		
Calendar Year Deductible	\$200 individual; \$600 aggregate amount per family	\$350 individual; \$1,050 aggregate amount per family
Lifetime Maximum	\$1,000,000	\$2,000,000 Comprehensive lifetime maximum
BENEFITS FOR OTHER COVERED SERVICES		
Physical Therapy	80% subject to calendar year deductible	80% subject to calendar year deductible Occupational, physical and speech therapy limited to combined maximum of 30 visits per year
Occupational Therapy	80% subject to calendar year deductible Limited to certain services related to hand and lymphedema	80% subject to calendar year deductible Occupational, physical and speech therapy limited to combined maximum of 30 visits per year
Speech Therapy	Not covered	80% subject to calendar year deductible Occupational, physical and speech therapy limited to combined maximum of 30 visits per year
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
Inpatient Hospital Up to 30 days of inpatient treatment during any 12 consecutive months; no coverage after 30 days	100% after \$200 inpatient per admission deductible; \$50 per day hospital copay days 2-6 for each admission	100% after \$150 per day hospital copay for days 1-5 for each admission, no deductible per admission
HEALTH MANAGEMENT BENEFITS		
Contraceptive Management Covers prescription contraceptives, which include: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance	Not covered	Covered

This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.

5/26/2009